North Central Health Care
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OFFICIAL NOTICE AND AGENDA of a meeting of the Board or Committee

A meeting of the **North Central Community Services Program Board** will be held at **North Central Health Care, 1100 Lake View Drive, Wausau, WI 54403, Wausau Board Room** at **12:00 PM** on **Thursday, July 28th, 2016**.

(In addition to attendance in person at the location described above, Committee members and the public are invited to attend by telephone conference. Persons wishing to attend the meeting by phone should contact Debbie Osowski at 715-848-4405 24 hours prior to the start time of the meeting for further instructions.)

AGENDA

1. Call to Order
2. Public Comment for Matters Appearing on the Agenda
3. Consent Agenda
    a. ACTION: Approval of 6/30/16 Board Meeting Minutes
4. Educational Presentation
    a. Population Health Outcomes and Presentation on Collective Impact Model - B. Schultz and Judy Burrows, Marathon County Health Department
5. Committee Reports
    a. Chairperson's report - J. Zriny
        1) Review Draft Minutes of the 7/13/16 Executive Committee meeting
    b. Finance, Personnel & Property Committee Report - B. Weaver
        1) Review Draft Minutes of the 6/30/16 Finance, Personnel & Property Committee Meeting
        2) Overview of the 7/28/16 Finance, Personnel & Property Committee Meeting
    c. Quality Committee Report – J. Kelly
        1) Motion to Accept Organizational Quality Dashboard
        2) Overview of the 7/21/16 Quality Committee Meeting
    d. Human Services Operations Committee Report - J. Robinson
        1) Review Draft Minutes of the 7/18/16 Human Services Operations Committee Meeting
    e. Nursing Home Operations Committee Report: J. Burgener
        1) Review Draft Minutes of the 7/15/16 Nursing Home Operations Committee Meeting
6. Financial Report - B. Glodowski
    a. ACTION: Motion to Accept the Financial Report and June Financial Statements
7. Review of 2016 Financial Performance Analysis and Forecast – M. Loy
    a. ACTION: Board Direction on Recommendations to Address Financial Performance for 2016
8. Operational Plan Update – B. Schultz
    a. Update on Crisis Process Improvement Initiatives – L. Scudiere and B. Schultz
9. Discussion of Morningside Report – M. Loy
10. Update on Policy Question, Transition Oversight Task Force and Decision Making Process for Marathon County – J. Zriny
11. CEO Report – M. Loy
12. Discussion of Future Agenda Items for Board Consideration or Committee Assignment
13. Adjourn

- If time permits, beginning discussions may take place on future agenda items.
- Action may be taken on any agenda item.
- In the event that any individuals attending this meeting may constitute a quorum of another governmental body, the existence of the quorum shall not constitute a meeting as no action by such body is contemplated.

Signed: /s/Michael Loy
Presiding Officer or His Designee

COPY OF NOTICE DISTRIBUTED TO:

Wausau Daily Herald
Antigo Daily Journal
Tomahawk Leader
Merrill Foto News
Lincoln & Marathon County Clerk Offices

DATE: 07/22/16 TIME: 4:00 PM
VIA: X FAX X MAIL
BY: D. Osowski

THIS NOTICE POSTED AT:

North Central Health Care
DATE: 07/22/16 TIME: 4:00 PM
By: Debbie Osowski

Any person planning to attend this meeting who needs some type of special accommodation in order to participate should call the Administrative Office at 715-848-4405. For TDD telephone service call 715-845-4928.

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
BOARD MEETING MINUTES

June 30, 2016 | 12:00 Noon | NCHC – Wausau Campus

Present:

X	Randy Balk	X	Steve Benson	X	Ben Bliven
X	Jean Burgener	EXC	Joanne Kelly	X	Holly Matucheski
X	Bill Metter	X	Bill Miller	EXC	Scott Parks
X	John Robinson	EXC	Greta Rusch	EXC	Robin Stowe
X	Bob Weaver	X	Jeff Zriny		

Also present: Michael Loy, Brenda Glodowski, Laura Scudiere, Becky Schultz, Sue Matis, Debbie Osowski

Guest: Kurt Gibbs, John Fisher

Meeting was called to order at 12:07 p.m., roll call taken, and a quorum noted.

Welcome given to Dr. Steve Benson, newest member of the Board. Dr. Benson has a mental health background, and is familiar with the community and North Central Health Care.

Welcome also given to Kurt Gibbs, Chairman of the Marathon County Board, and John Fisher, Attorney with Ruder Ware.

Approval of Consent Agenda

- **Motion**/second, Burgener/Metter, to approve the consent agenda which includes the 5/26/16 Board Meeting Minutes. Motion carried.

Chairman's Report

- Minutes of 6/14/16 Executive Committee meeting were reviewed.
- Waiting for Morningside Report from Marathon County regarding the study on the human services model.
  - July 11 – 7 p.m. - Morningside will present their report at a special meeting of the Marathon County Board
  - July 12 – 7 a.m. - Morningside will meet with the Marathon County Executive Committee
  - July 12 – 8:30 a.m. Morningside will meet with the Transition Task Force Meeting
  - July 18 - The Task Force will make recommendation for the Health & Human Services Committee meeting scheduled for August 8
  - August 18 - An open public meeting to comment on the options. (see schedule in packet)

Finance, Personnel & Property Committee Report

- May 26, 2016 Finance, Personnel & Property Committee minutes were reviewed.
- June 30 meeting discussion included the fact that there has been no action by Marathon County regarding the Performance Management Contract; contributing factors to current deficit relate to several high health insurance claims, out of county placements for individuals under age 13, and several requiring long term psychiatric care.
- An action plan to address the budget concerns will be reviewed next month.
- No significant write-off's.
- Committee received an update on the 2017 budget process.
- Discussed our investment policy with Kristi Kordus, Marathon County Finance, and compared it to Marathon County's investment policy. Currently we have a simple investment strategy and we are looking for other options with recommendations from Marathon County.

Financial Report

- Showed loss for May just over $343,000. Contributors go back to the census areas i.e. Nursing home census is down, and hospital census is down which has not happened in a long time.
- Experienced an overage in health insurance of about $119,000 in May. Staff are meeting regularly to address and will be looking at potential plan changes for next year.
- Diversions continue to be an issue i.e. state institutes and Trempealeau County are over by $300,000 for the month of May. We also do not treat anyone under age 13, and only allow 2 juveniles on the unit at one time. We are an acute hospital to stabilize individuals and then move them if needing long term psychiatric care if needed.
- Revenue issues to be addressed for end of year. Will come back with recommendations for remainder of 2016 to set up budget for next year.
- **Motion**/second, Weaver/Balk, to accept the financials. Motion carried.

Quality Committee Report

- Organizational Quality Dashboard was reviewed.
- **Motion**/second, Robinson/Weaver, to accept the Organizational Quality Dashboard. Motion carried.

Human Services Operations Committee Report

- The July 8 meeting is being rescheduled.
- Committee discussing outcomes and outputs, what is meaningful data, managing those coming out of jail system, OWI assessment treatment, contacts, finances, vacancies in outpatient service areas, and Dr. Ticho transition from inpatient to outpatient services.
- Began discussion relative to juvenile justice system with collaborative approach in what we are seeing to address the need. Will be working with Laura Yarie and other partners to define the needs along with the Morningside report.

Nursing Home Operations Committee Report

- Margaret Donnelly from Aspirus has joined the committee.
- Both the State Region 5 Surveyors and several Federal surveyors visited Mount View Care Center recently in response to a self-report and did not find any issues with how the nursing home performed in the care related to the complaint.

Review and Endorsement of Collaborative Care Quality Committee Charter

- The Committee brings many partners together, focuses on quality improvement, and is a good product for the three county partners.
- Once Committee Charter is finalized and approved, the document will be presented to the three counties for consideration, and then brought back to the NCCSP Board for amendments to the bylaws to create the committee structure.
- John Fisher provided a presentation and review of the Collaborative Care Quality Committee Charter.
- Following discussion, **motion**/second, Metter/Weaver, to approve the Charter and present to the three Counties for input and endorsement.
  - Board recommended deleting Section 7.13 from the Charter.
  - Motion carried with noted revision.

Presentation on Collective Impact

- Presentation postponed to the July meeting.

Discussion of Morningside Report

- Report was projected to be available two weeks before but report has not been provided yet.

CEO Report

- Annual reports have been distributed.
- Had meetings scheduled to review the report with all three County Board supervisors. Due to low participation the events were cancelled. Have talked with county board chairs for the opportunity to speak at upcoming County Board meetings to answer questions.
- NCHC has been accepted into the LeadingAge Network to help us contract with payers throughout the state.
- With Dr. Ticho transitioning from full-time inpatient to part-time outpatient we are diligently working to retain psychiatrists to cover the inpatient unit. Contracted staff has been secured at this time. Have been recruiting for 3 months but no prospects yet.
- In contact with a child psychiatrist. Potential for a visit July 15.
- Continuing to work on maintenance transition to be effective 1/1/17.
- Continue to meet with Langlade and Lincoln Counties to develop options should Marathon County withdraw.
- July 20 Sen. Tammy Baldwin is visiting North Central Health Care; interested in the MMT program; we are hosting a round table discussion with community partners on opioid.

Discussion of Future Agenda Items for Board Consideration

- None noted

Motion/second, Robinson/Miller, to adjourn the NCCSP Board Meeting. Motion carried. Meeting adjourned at 1:30 p.m.

dko

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MEMO

DATE: July22, 2016
TO: North Central Community Services Program Board
FROM: Becky Schultz, Senior Executive- Quality and Clinical Support Services
RE: Population Health Efforts

Purpose

To discuss the direction of North Central Health Care's (NCHC) quality measurement and improvement system as a foundation to effectively contribute to community-based population health outcomes.

Background

In 2012, the North Central Community Services Program Board approved NCHC's Excellence in Quality Plan. This Plan, and subsequent annual updates to this Plan, defines the commitment, and formal organizational structures, actions, and processes to ensure the quality of services at NCHC. A critical component of this Plan has been the establishment of measurement systems to effectively report the quality of services at NCHC. These measurements and structures have been expanded and improved over the last 5 years to:

- support effective evaluation of the quality of services at NCHC,
- fully integrate process improvement methodologies to improve care and services, and
- align with the public and industry direction of accountable care and population health.

In response to data discoveries and partner feedback obtained through the quality efforts, an emphasis on process improvement of services impacting other key community resources was initiated in 2015. A formal application of this was applied in the process improvement project to improve Crisis Services in the communities we serve. As a result, the cross-functional team made up of key community stake holders including emergency room providers, law enforcement, NCHC crisis staff, and private mental health providers has developed and initiated a plan to improve efficiency and effectiveness of Crisis Services in Marathon, Lincoln and Langlade counties. Initial data is indicating a positive effect on this process on this population and key community stakeholders.

Recommendation

The recommendation is that North Central Health Care Quality continue to invest in and develop its process improvement initiatives including the utilization of the Collaborative Care and Collective Impact models to support population health improvements in the communities we serve. Needs assessments in our three county region suggests a priority need in Substance Abuse prevention and treatment. NCHC is uniquely positioned to provide leadership resources for collective impact on these issues and, therefore, recommend prioritization of these efforts.

Financial Analysis

Continued support of resources to provide NCHC's active leadership and participation in community-based collective impact initiatives targeted at the populations that we serve.

Types of Quality Measures

Measures used to assess and compare the quality of health care organizations are classified as either a structure, process, or outcome measure. Known as the Donabedian model, this classification system was named after the physician and researcher who formulated it.

Structural Measures

Structural measures give consumers a sense of a health care provider's capacity, systems, and processes to provide high-quality care. For example:

- Whether the health care organization uses electronic medical records or medication order entry systems.
- The number or proportion of board-certified physicians.
- The ratio of providers to patients.

Process Measures

Process measures indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition. These measures typically reflect generally accepted recommendations for clinical practice. For example:

- The percentage of people receiving preventive services (such as mammograms or immunizations).
- The percentage of people with diabetes who had their blood sugar tested and controlled.

Process measures can inform consumers about medical care they may expect to receive for a given condition or disease, and can contribute toward improving health outcomes. The majority of health care quality measures used for public reporting are process measures.

Outcome Measures

Outcome measures reflect the impact of the health care service or intervention on the health status of patients. For example:

- The percentage of patients who died as a result of surgery (surgical mortality rates).
- The rate of surgical complications or hospital-acquired infections.

Outcome measures may seem to represent the "gold standard" in measuring quality, but an outcome is the result of numerous factors, many beyond providers' control. Risk-adjustment methods—mathematical models that correct for differing characteristics within a population, such as patient health status—can help account for these factors. However, the science of risk adjustment is still evolving. Experts acknowledge that better risk-adjustment methods are needed to minimize the reporting of misleading or even inaccurate information about health care quality.

What Are We Talking About When We Talk About Population Health?

David Kindig

April 6, 2015

The term population health is much more widely used now than in 2003 when Greg Stoddart and I proposed the following definition: *"the health outcomes of a group of individuals, including the distribution of such outcomes within the group."* The term is often seen in policy discussion, research, and in the name of new academic departments and institutes.

The term's growing use, most notably in the Triple Aim and in clinical settings, has resulted in a conflicting understanding of the term today. In this post, I discuss the evolution of the term population health, and argue that going forward multiple definitions are needed. While the traditional population health definition can be reserved for geographic populations, new terms such as *population health management* or *population medicine* are useful to describe activities limited to clinical populations and a narrower set of health outcome determinants.

Origins Of Population Health Terminology

The most influential contemporary contribution to how we understand population health is *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*, a 1994 book by Evans, Barer, and Marmor. No definition of the term appears there, although the concept is described as, “the common focus on trying to understand the determinants of health of populations.”

In my 1997 book, *Purchasing Population Health: Paying for Results*, I proposed the definition as, “the aggregate health outcome of health-adjusted life expectancy (quantity and quality) of a group of individuals, in an economic framework that balances the relative marginal returns from the multiple determinants of health.” This definition included the specific measure of population health (health-adjusted life expectancy) as well as consideration of the relative cost-effectiveness of resource allocation to multiple determinants.

This definition emphasized that there are investment tradeoffs, which required “an economic framework that balances the relative marginal returns from the multiple determinants of health.” While less appreciated as a hallmark of population health thinking, the economic tradeoffs are equally important. If resources were unlimited we wouldn’t have to make investment choices, but they are limited. A critical component of population health policy has to be how the most health return can be produced from the next dollar invested, such as expanding insurance coverage or reducing smoking rates or increasing early childhood education. This is important for clinical populations as emphasized by the Triple Aim, but also for geographic populations needing resources from both public and private sectors.

In our 2003 article, Stoddart and I simplified the definition to focus on general health outcomes. We were thinking broadly about groups of individuals and suggested that “these populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners.” At the time, the term typically referred to local geographic populations and had not yet been applied to the realm of medical care.

Multiple Determinants And Investment Tradeoffs

By 2003, Stoddart and I believed that the increasing emphasis on social determinants had led to an under-emphasis on specific measures of health. In response, we developed our shortened, simplified definition without the earlier emphasis on the multiple determinants of health and economic tradeoffs among them.

Some may argue that multiple determinants are so fundamental to population health that they deserve definitional status. I believe, however, that including multiple determinants in the definition could lead to confusion between the outcome goal and the determinants needed to achieve that outcome. This point is so important that the County Health Rankings grade the health of America’s counties on two components: reported outcomes (such as low birthweight), and factors determining that outcome (in the case of low birthweight, access to care and child poverty rates).

Health Disparities

The second phrase in the 2003 definition, "*including the distribution of such outcomes within the group"* deserves serious attention. We often state that our national and local goals are improving overall health *and* reducing disparities. Unfortunately in measurement, policy, and research, we often emphasize the average or overall, such as setting future life expectancy targets, but without such attention and specificity to the disparity reduction component.

A common assumption is that improving overall population health also reduces gaps by race, socioeconomic status (SES), and geography, but this is not always the case. Many times these goals compete with each other, such as quicker take up in health behaviors by more educated persons actually increasing disparities. Often policy tradeoffs are required. If we truly believe that reducing disparities by race and SES is just as important as improving overall health, we need to give them equal attention, as we did in the original 2003 definition.

The Triple Aim And Population Health Management

The past six years have seen the prominent development of the Triple Aim, which proposes three linked goals — improving the individual experience of care, reducing per capita cost of care, and improving the health of populations. This framework provided a boost in the use of the term *population health*.

In particular, its promotion by the Institute for Healthcare Improvement and the Centers for Medicare and Medicaid Services has led many health care organizations to use it to describe the clinical (often chronic disease) outcomes of enrolled patients. And many clinicians and medical managers have begun to use the terms *population health management* or *population medicine*. For example, the Symphonycare website defines *population health management* as "the iterative process of strategically and proactively managing clinical and financial opportunities to improve health outcomes and patient engagement, while also reducing costs."

Do We Now Need Two Definitions Of Population Health?

I believe the answer is yes. Some have argued that the term should be reserved strictly for referring to geographic populations. But given how widely the term is now used in clinical settings, that is not realistic.

That is not ideal, because I believe that defining *population health* in terms of clinical populations draws attention away from the critical role that non-clinical factors such as education and economic development play in producing health. For this reason, I believe that when referring to patient populations, we should use the term *population health management* or perhaps even better, *population medicine*.

The traditional *population health* definition can then be reserved for geographic populations, which are the concern of public health officials, community organizations, and business leaders. For this reason, Jacobson and Teutsch recommended to the National Quality Forum that "current use of the abbreviated phrase *population health* should be abandoned and replaced by the phrase *total population health*."

This will avoid confusion as the clinical care system moves rather swiftly toward measuring the health of the subpopulations they serve. Geopolitical areas rather than simply geographic areas are recommended when measuring total population health since funding decisions and regulations are inherently political in nature.

I understand this argument, but prefer that the modifiers "management" or "medicine" be used for clinical populations. I agree with the decision of the Institute of Medicine (IOM) Roundtable on Population Health Improvement, which chose "to retain the shorter term population health while acknowledging that we use it in the spirit of the Jacobson-Teutsch critique."

Improving such total population health requires partners across many sectors—including public health, health care organizations, community organizations, and businesses—to integrate investments and policies across all determinants.

Many progressive health care organizations are doing cutting edge *population health management*, but are also working with other partners on *total population health* across geographic populations, such as the approach Health Partners board has taken in the Twin Cities. In such cases, it would be appropriate to label these efforts as *population medicine expanding into total population health.*

Semantics like this can seem arcane, but they also ensure that we clearly understand each other. For the next decade we need to be clear about these two ways of thinking about population health, how they interact, and the important work going on in both of them.

Measuring Population Health Outcomes

R. Gibson Parrish, MD

Suggested citation for this article: Parrish RG. Measuring population health outcomes. Prev Chronic Dis 2010;7(4):A71. http://www.cdc.gov/pcd/issues/2010/jul/10_0005.htm. Accessed [*date*].

PEER REVIEWED

Abstract

An ideal population health outcome metric should reflect a population's dynamic state of physical, mental, and social well-being. Positive health outcomes include being alive; functioning well mentally, physically, and socially; and having a sense of well-being. Negative outcomes include death, loss of function, and lack of well-being. In contrast to these health outcomes, diseases and injuries are intermediate factors that influence the likelihood of achieving a state of health. On the basis of a review of outcomes metrics currently in use and the availability of data for at least some US counties, I recommend the following metrics for population health outcomes: 1) life expectancy from birth, or age-adjusted mortality rate; 2) condition-specific changes in life expectancy, or condition-specific or age-specific mortality rates; and 3) self-reported level of health, functional status, and experiential status. When reported, outcome metrics should present both the overall level of health of a population and the distribution of health among different geographic, economic, and demographic groups in the population.

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By far, the most fundamental use of summary measures of population health is to shift the centre of gravity of health policy discourse away from the inputs . . . and throughputs . . . of the health system towards health outcomes for the population. This is not to imply that the resources used and activities undertaken by national or regional health systems are unimportant; quite the contrary. But our understanding of their roles and importance is more appropriate if guided by the real "bottom line," namely their influence on population health.

Michael C. Wolfson (1)

Definitions and Introduction

The World Health Organization defines health as "the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (2). To achieve this vision of health for its members, a healthy society must establish and sustain conditions, including a healthful natural and built environment, and equitable social and economic policies and institutions, that ensure the "happiness, harmonious relations, and security of all [its] peoples" (2,3). Positive health outcomes for people include being alive; functioning well mentally, physically, and socially; and having a sense of well-being.

The level and distribution of health outcomes in populations result from a complex web of cultural, environmental, political, social, economic, behavioral, and genetic factors (Figure). In this causal web, diseases and injuries are intermediate factors, rather than outcomes, that may influence a person's health. Lung cancer, for example, has a substantial effect on physical function and lifespan, while first-degree sunburn has little effect. Health outcome metrics are standards for measuring health outcomes. Recommending a set of metrics for monitoring a population's health outcomes — as opposed to a person's health outcomes — is the objective of this essay.

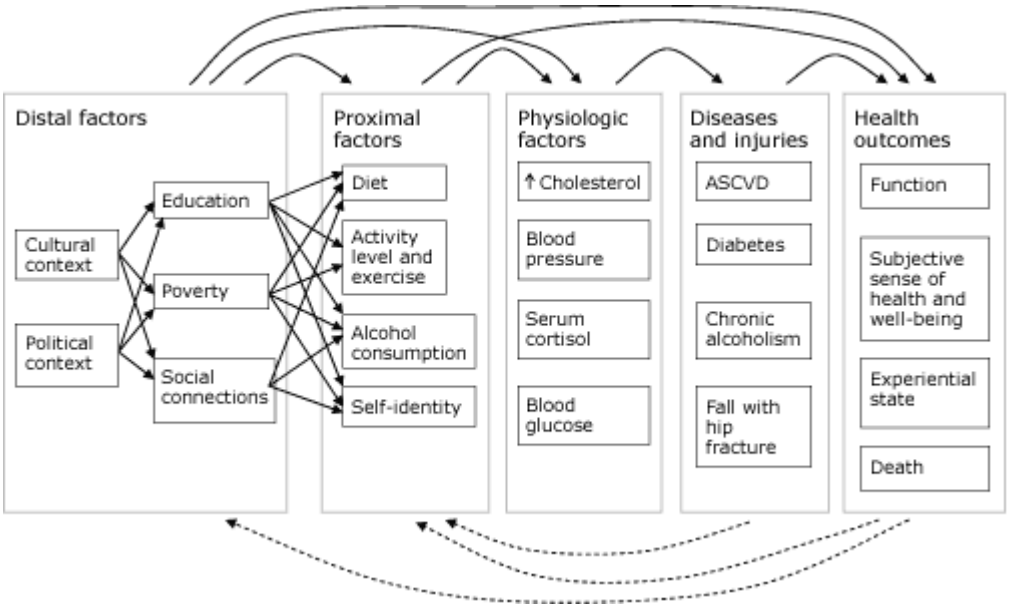

Figure. A causal web that illustrates various factors influencing health outcomes and interactions among them. Solid arrows represent potential causal relationships between factors, diseases, and outcomes. Dashed arrows represent potential feedback from outcomes and diseases on proximal and distal factors. Distal and proximal factors operate through both intermediate factors and directly on health outcomes. For example, a person's level of education can directly influence his or her subjective sense of health and level of social function and also influence intermediate factors, such as diet and exercise. Similarly, the understanding that death or loss of function may occur as the result of a person's lifestyle or social and economic factors, such as education and poverty, may influence those factors through either behavior change or changes in social or economic policy. Examples of factors, diseases, and injuries were chosen to provide a sense of the breadth of available factors. To improve readability, the relationships among proximal factors, physiologic factors, diseases and injuries, and health outcomes have been simplified. Adapted from references 4-6. Abbreviation: ASCVD, atherosclerotic cardiovascular disease.

Three approaches to measuring population health outcomes are available: 1) aggregating health outcome measurements made on people into summary statistics, such as population averages or medians; 2) assessing the distribution of individual health outcome measures in a population and among specific population subgroups; and 3) measuring the function and well-being of the population or society itself, as opposed to individual members. According to the definition of a healthy population, the third approach is the most appropriate because it focuses on how well the population produces societal-level conditions that optimally sustain the health of all people. These societal-level conditions, although not yet fully characterized or understood, most likely include an equitable distribution of power, opportunity, and resources among a population's members; social connections and interactions built on norms of reciprocity and trustworthiness (3); and environmental policies and practices that sustain the quality of the population's land, water, air, native vegetation, and animal life. These societal-level conditions may be viewed as social, economic, political, and environmental determinants of health, rather than as health outcomes, and as such are addressed by other articles in this issue of *Preventing Chronic Disease*. I focus on approaches to assessing population health outcomes in which measures of population health are constructed from the aggregation of individual-level health measures, such as mortality, functional status, and self-perceived health.

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Basic Outcome Metrics for Population Health

Measures of mortality, life expectancy, and premature death

Box 1. Examples of Population Health Outcome Metrics Based on Mortality or Life Expectancy
Mortality

Crude mortality rate
Age-adjusted mortality rates (AAMR)
Age-specific mortality rate
Neonatal (<28 d)
Infant (<1 y) (infant deaths per 1,000 live births)
Under 5 y
Adult (15-60 y)
Other characteristic-specific mortality rates
State- or county-specific
Sex-specific
Race-specific
Condition-specific mortality rates and similar measures
Disease-specific mortality rate
Injury-specific mortality rate
Leading causes of death
Smoking-attributable mortality (number of deaths)
Maternal mortality ratio
Occupational class-specific mortality rate
Life expectancy
Life expectancy at birth
Life expectancy at age 65 y
Premature mortality
Years of potential life lost
Premature mortality rate
Summary measures of population health
Health-adjusted life expectancy at birth (y)
Quality-adjusted life expectancy
Years of healthy life
Healthy life years
Disability-adjusted life years
Quality-adjusted life years
Inequality measures
Geographic variation in AAMR among counties in a state (standard deviation of county AAMR/state AAMR)
Mortality rate stratified by sex, ethnicity, income, education level, social class, or wealth
Life expectancy stratified by sex, ethnicity, income, education level, social class, or wealth

Box 2. Examples of Population Health Outcome Metrics Based on Subjective (Self-Perceived) Health State, Psychological State, or Ability to Function[a]
Health state
Percentage of adults who report fair or poor health
Percentage of children reported by their parents to be in fair or poor health
Mean number of physically or mentally unhealthy days in the past 30 days (adult self-report)

Mean number of mentally unhealthy days in the past 30 days (adult self-report)
Mean number of physically unhealthy days in the past 30 days (adult self-report)
Experiential and psychological state
Percentage of adults with serious psychological distress (score ≥13 on the K6 scale)
Percentage of adults who report joint pain during the past 30 days (adult self-report)
Percentage of adults who are satisfied with their lives
Ability to function
Percentage of adults who report a disability (for example, limitations of vision or hearing, cognitive impairment, lack of mobility)
Mean number of days in the past 30 days with limited activity due to poor mental or physical health (adult self-report)
[a] Categories adapted from reference 9.

People and societies value life and health, although the relative value placed on long life versus well-being during life varies. Mortality and life expectancy are 2 basic measures of population health (Box 1).

The number of deaths that occur in a population during a period of time (usually 1 year) divided by the size of the population is the population's crude mortality. Because age is such a strong predictor of death and the age distributions of members of different populations vary, a population's mortality rate is commonly adjusted by using a standard age distribution to produce an age-adjusted mortality rate. The age-adjusted mortality rate allows comparison of mortality across different populations. One may also calculate mortality rate for a group in a population on the basis of a specific characteristic, such as age, sex, or geographic area, to yield a characteristic-specific mortality rate. Another method of assessing the effect of mortality on a population is to calculate the life expectancy of its members. Typically, this is calculated as the life expectancy at birth, although it may be calculated as the remaining life expectancy for any given age. Measures of premature death, including years of potential life lost and the premature mortality rate, quantify mortality among people younger than a particular age, typically 65 or 75 years.

Although these measures provide information about mortality and longevity, they provide no information about the contribution of specific diseases, injuries, and underlying conditions (for example, water quality, poverty, social isolation, and diet) to death, for which actions might be taken to prolong life. For this reason, disease-specific mortality rates are frequently used to illustrate the contribution of specific diseases to population mortality. Recent work extends this concept and proposes methods and measures for estimating the contributions of more fundamental causes to mortality, such as the distal and proximal factors exemplified in the causal web of the Figure (5,7,8).

Measures of health, function, and subjective well-being

Societies and their members typically value health both subjectively (freedom from pain and suffering, joy, happiness, sense of self-worth and value to others) and objectively (ability to perform physical, mental, and social tasks) (Box 2). Measuring health in a standardized way that allows comparisons among people, countries, and cultures and over time is challenging. Various approaches, some of which have proved controversial, have been developed and used in the past 40 years. They include methods to assess and classify the health, function, and disability of members of a population, for example, the International Classification of Functioning, Disability, and Health (10), and methods to estimate the overall health of populations.

Measurements of self-perceived or "self-rated" health, functional status, and experiential state typically rely on population health surveys, such as the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS) in the United States, the European Union's Statistics on Income and Living Conditions, and the World Health Organization's World Health Survey. Care must be taken, however, when comparing metrics derived from different surveys: the nature and wording of questions and the time period covered may differ. Furthermore, the interpretation of health categories, such as "good" and "poor," may vary culturally among countries or even among different populations in a country. The authors of a recent study of 4 US national surveys even questioned whether self-rated

health is a suitable measure for tracking population health over time because of inconsistencies in self-ratings over time among surveys and certain population subgroups (11).

Health-related quality of life (HRQL) indices are also used to quantify health and to analyze cost-effectiveness. These indices are based on interviewer- or self-administered questionnaires that address various health dimensions or domains, such as mobility, ability to perform certain activities, emotional state, sensory function, cognition, social function, and freedom from pain. Six such indices, several of which are proprietary, are used in the United States: the EuroQol EQ-5D; the Health Utilities Index Mark 2 and Mark 3; the Quality of Well-Being Scale, self-administered form; the SF-6D; and the HALex (12). More detailed descriptions of these indices are available (9,12). The Centers for Disease Control and Prevention has also developed HRQL measures that are used in BRFSS and the National Health and Nutrition Examination Survey (NHANES); these measures were recently validated against the SF-36v2 (13,14).

Although not direct measures of health and well-being, the incidence or prevalence of specific diseases and rates for accessing and using health care are frequently used as surrogates for disability, loss of function, or lack of well-being. Ascertaining the incidence and prevalence of disease may be accomplished through the use of disease registries, health records, and population surveys.

Summary measures of population health

Summary measures of population health have been developed in the past 40 years as an alternative to or extension of the basic metrics described above. The purpose of these summary measures is to "combine information on mortality and nonfatal health outcomes to represent the health of a particular population as a single numerical index" (15). These summary measures are based on reductions in life expectancy to account for disability or other measures of poor health; they provide estimates of either the expected number of future years of healthy life at a given age or the number of years that chronic disease and disability subtract from a healthy life.

In 1971, Sullivan described techniques for calculating 2 summary health indices — life expectancy free of disability and disability expectancy — by combining mortality rates from period life tables and survey-based disability rates (16). Subsequent work has produced other summary population health measures, including health-adjusted life expectancy, quality-adjusted life expectancy, years of healthy life, healthy life years (also known as disability-free life expectancy), disability-adjusted life years, and quality-adjusted life years. These measures vary by whether they use the actual or an idealized life expectancy for the population; whether they value all years of life and disability equally or discount certain years, such as childhood and old age; whether they are expressed as an adjusted life expectancy or as a sum of the years of disability for the entire population; and how they estimate the population's health, prevalence of chronic disease, or prevalence of disability. Estimates of population health and disability are typically derived from either expert judgment in conjunction with published literature or survey data — both population and convenience samples have been used — on function, self-perceived health, and psychological or sensory distress. Along with continuing debate about methodologic issues, ethical concerns about the use of summary measures and the way in which they value life have been raised (15,17,18). Several excellent reviews on summary measures of population health and these issues are available (9,15,17,18).

Measures of the distribution of health in a population

Measures of the distribution of health in and among populations are as relevant as measures of the level of health in and among populations (15). Understanding the distribution of health can focus attention and action on specific health determinants and population groups to reduce inequalities in health and improve the overall level of health. Although the distribution of health outcomes could be assessed on any measurable geographic, demographic, social, or economic characteristic, some researchers argue that health inequalities should be assessed by using specific social and economic characteristics that have historically determined social status (for example, wealth, ethnicity, sex, educational attainment) (19). Others suggest that this viewpoint excludes potentially relevant determinants of health (20). Metrics to assess the distribution of outcomes include measures of inequality (Gini index), measures of association

(rate ratio), measures of impact (population-attributable proportion), and measures based on ranking (concentration index) (21,22).

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Attributes of a Good Health Outcome Metric

Several groups have proposed criteria for assessing and selecting specific health indicators (Table 1). Their criteria include the need for the indicators to 1) further the goals of their organization, 2) be valid and reliable, 3) be easily understood by people who use them, 4) be measurable over time, 5) be measurable for specific geographically or demographically defined populations, 6) be measurable with available data sources, and 7) be sensitive to changes in factors that influence them, such as socioeconomic or environmental conditions or public policies (23-25).

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Current Metrics for Population Health Outcomes

In 2008, Wold reviewed 35 sets of health indicators in use (26). Although not an exhaustive list, these 35 sets provide a representative view of health indicators and their intended uses, which include presenting a picture of the health of a place, stimulating action to improve health, and tracking progress toward meeting objectives (Table 2). No set of indicators is explicitly used as a guide to financially reward improvement in health outcomes.

Wold grouped the indicator sets into 4 overall categories: general health (14 sets), quality of life (5 sets), health systems performance (11 sets), and "other" (5 sets). She further divided the general health category into national (7 sets) and state and local (7 sets). These 35 indicator sets contain various health measures, only a few of which are outcome measures. Frequently used outcome indicators are infant mortality rate, condition-specific mortality rate, age-adjusted mortality rate, years of potential life lost, life expectancy at birth, leading causes of death, and percentage of adults who report fair or poor health.

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Data and Analytical Issues for Population Health Outcome Metrics

Available data sources

The principal sources of data available for US population health outcomes are mortality data derived from death certificates and data on subjective health status, functional status, and experiential state derived from population health surveys. The National Vital Statistics System (NVSS) collects and compiles data on births and deaths from all registration districts (most commonly states) in the United States. The most commonly used surveys are NHIS, BRFSS, NHANES, and the National Survey on Drug Use and Health (NSDUH). Several states conduct city- or county-level risk factor surveys by using BRFSS methods and questions, and an increasing number of cities and counties now conduct their own surveys based on or derived from BRFSS. A few states and local areas (Wisconsin and New York City, for example) conduct surveys based on NHIS or NHANES methods to provide state or local estimates of health outcomes and determinants.

Geographic units of analysis

Mortality data are available for states and counties. Some states geocode their vital statistics data and provide data — usually through a Web-based data query and mapping tool — for zip codes, census tracts, or locally defined areas. BRFSS provides state-level estimates and estimates for selected metropolitan

statistical areas with 500 or more respondents. Several states, including Florida, North Dakota, Washington, and Wisconsin, conduct their own county-level BRFSS to produce estimates for at least some of their counties. NSDUH provides national and state estimates. NHIS and NHANES only provide national estimates.

Validity and precision of the measures

The validity and precision of mortality data — at least the number of people who die in a given time period in a given place — are high, as death registration is virtually complete in the United States. Condition-specific mortality data may be less valid because of errors in determining and coding the cause of death.

The designs of NHIS and NHANES to ensure that their samples are representative of their target populations and their high response rates (75%-90%) are indicators of high validity. Precision of estimates is related to sample size and the amount of variation of the characteristic being estimated in the target population. The size of the NHIS sample is sufficient to provide national estimates for the total population with relative standard errors of 1% to 3%, although relative standard errors of estimates for small subgroups may be as high as 10% to 30%. To provide more precision, NHIS oversamples some population subgroups. Estimates may be obtained for most states by combining data collected in several years.

Response rates for BRFSS, a state-based telephone survey, are considerably lower than for NHIS and NHANES. For example, state response rates for the 2008 survey ranged from 20% (Connecticut) to 58% (Utah), and the median was 34% (35).

Measuring trends

NVSS, NHIS, BRFSS, and NSDUH provide data annually, and NHANES provides data every 2 years. National trends can be measured by using any of these data sources, state trends can be measured by using NVSS and BRFSS, and county trends can be measured by using NVSS.

Annual trends in crude and age-adjusted mortality rate and in life expectancy since the mid-1900s are available for the United States at the national, state, and county levels. See, for example, an analysis of trends in county-level mortality (36), life expectancy at birth by race and sex from 1900 through 2005 (37), and average annual age-adjusted mortality by race, Hispanic origin, and state for 1979 through 1981, 1989 through 1991, and 2003 through 2005 (37). Trend data on mortality are also available for selected causes of death (37).

Trends in HRQL, assessed by using CDC's HRQOL-4 measures derived from BRFSS, are available for the United States and for each state from 1993 through 2008, the most recent year for which BRFSS data are available (13). CDC is generating county-level estimates for the following 3 CDC HRQOL-4 measures for 2001 through 2007 for the MATCH (Mobilizing Action Toward Community Health) county rankings by using BRFSS data: percentage who report fair or poor health, physically unhealthy days in the past 30 days, and mentally unhealthy days in the past 30 days. Neither national-, state-, nor county-level population data are available for the other HRQL indices. Their use has typically been in the clinical or research setting for assessing medical or surgical therapies. The Health Utilities Index has been used in Canada for 4 major population health surveys. Although many studies document the validity of various HRQL indices, fewer studies document their reliability or responsiveness to change over time.

Measuring inequalities in health

Several characteristics are available from NVSS and each of the surveys for measuring the dependence of population health on social and economic factors (Table 3). All systems provide these 5 characteristics for analysis: age, education level, ethnicity, race, and sex. Because of the limited availability of data for smaller geographic units, none of the systems can measure inequalities in health at the county level, except NVSS.

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Recommendations

"No single measure can capture the health of the nation" (24). On the basis of this review of existing health outcome metrics and data available for counties, I recommend the following metrics for population health outcomes at the county level.

Life expectancy from birth or age-adjusted mortality rate

This metric mirrors a relevant outcome, data are readily available to assess temporal trends and geographic and demographic variation, and mortality is amenable to population health interventions, although changes in the mortality metric may take years to appear. Life expectancy has the advantage of being more easily communicated to, and understood by, the public than mortality rates.

Condition-specific changes in life expectancy or condition- or age-specific mortality rate

This metric has the advantages of the overall mortality metric, as above, and allows public health programs to monitor the effect of specific interventions on more specific outcomes. An example might be monitoring increases in life expectancy or reductions in motor vehicle injury-related mortality resulting from efforts to modify driver behavior and to make roads and vehicles safer.

The conditions should be selected on the basis of local needs assessments (for example, conditions that dramatically affect mortality that could be addressed by local population health programs or other interventions). Alternatively, if states or counties needed to be compared directly, a fixed set of conditions could be selected, similar to conditions that the Institute of Medicine recommended for the State of the USA indicators (infant mortality and injury-related mortality).

Self-perceived level of health, functional status, or experiential state

This metric reflects the population's state of health and functional level and might provide a more immediate measure of the effect of interventions than the mortality metrics. Age-, sex-, and race-specific versions of the metric could provide at least some population specificity, which might be useful in monitoring the effect of interventions.

Although many of the HRQL instruments already in general use would work well for this metric, most of the instruments are proprietary, and state- and county-level data are not available from any of them. CDC's HRQOL-4 is probably the most viable option for this measure, as it is not proprietary and state-level data have been available since 1993. By using moving averages or other methods of aggregating data, county-level trend estimates could be developed even for small counties. Although data from CDC's HRQOL-4 are readily available, a more robust measure of HRQL, with specific questions about activity limitation, functional status, and experiential state, should be explored and adopted in the future (38). The CDC HRQOL-14, other HRQL indices described above, and work by Statistics Canada and REVES (Réseau Espérance de Vie en Santé, http://reves.site.ined.fr/en/home/about_reves) should be considered for this role.

Distribution of population health outcomes

Metrics that provide only the average level of health in a population may mask inequalities in the distribution of health, with policy and programmatic implications. Metrics that provide information on the distribution of health are another component of a complete picture of population health (1,15). Such metrics would measure the inequalities in health among different geographic, economic, and demographic populations.

One geographically based metric is the rate difference between the highest and lowest county life expectancies or age-adjusted mortality rates in a state. America's Health Rankings introduced a measure in 2008 on the variation in mortality among counties in each state (27). A demographically based metric might be the difference between the highest and lowest sex- and race-specific life expectancies or age-adjusted mortality rates in a state. An economically based metric might be the difference in life expectancies or age-adjusted mortality rates between the highest and lowest income deciles in a state.

An optional summary measure of population health

Summary measures of population health, which combine information on death and nonfatal health outcomes, have the advantage of simplicity and parsimony and may be easier to communicate to the public and track over time than the series of basic measures previously recommended. If a summary measure is desirable, the health-adjusted life expectancy and healthy life years are good choices because they are based on life expectancy and use a population-based measure of HRQL, rather than an expert judgment-based measure.

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Tables

Table 1. Criteria Used to Select Health-Related Indicators by 2 Institute Of Medicine Committees and Criteria Proposed to Select Global Health Indicators

Criteria[a] for Selecting an Indicator	Leading Health Indicators (23)	State of the USA Indicators (24)	Global Health Indicators (25)
Indicator is well-defined.			X
Indicator is worthwhile or important.	X	X	
Indicator is valid and reliable.	X	X	X
Indicator can be understood by people who need to act.	X		X
Indicator galvanizes action.	X		X
Action can improve the indicator.	X		
Measuring the indicator over time reflects effect of action.	X		
Measuring the indicator is feasible.			X
Data for the indicator are available for various geographic levels (local, national) and population subgroups.	X	X	X
Indicator is sensitive to changes in other societal domains (socioeconomic or environmental conditions or public policies).		X	

[a] The criteria for selecting indicators were compiled from the 3 reports cited. An "X" indicates that a report proposed using this criterion for selecting indicators.

Table 2. Stated Purposes of 9 Health Indicator Sets[a]

Indicator Set	Purpose

America's Health Rankings (27)	To stimulate action by people, communities, public health professionals, health industry employees, and public administration and health officials to improve the health of the population of the United States
Boston Indicators Project (28)	To democratize access to information, foster informed public discourse, track progress on shared civic goals, and report on change in 10 sectors
Community Health Status Indictors (29)	To provide an overview of key health indicators for local communities and to encourage dialogue about actions that can be taken to improve a community's health
Georgia Health Equity Initiative (30)	To look holistically at the major factors that influence differences in health status and their relationship to racial and ethnic characteristics
Healthy People 2010 Leading Health Indicators (31)	To define health objectives for the United States and track progress toward meeting them
Institute of Medicine, State of the USA Health Indicators (24)	To help Americans become more informed and, therefore, active participants in focusing public debate on important issues . . . To provide the most reliable and objective facts about the state of the United States and to serve as a tool for Americans to track the progress made on a broad range of issues, such as education, health, and the environment
Los Angeles County, Key Indicators of Health (32)	To monitor key health conditions and to engage a broad community of stakeholders in health improvement work
Robert Wood Johnson Foundation Commission to Build a Healthier America (33)	To raise visibility of the many factors that influence health, examine innovative interventions that are making a difference at the local level and in the private sector, and identify specific, feasible steps to improve Americans' health
Wisconsin County Health Rankings (34)	To summarize the current health of the counties as well as the distribution of key factors that determine future health . . . To encourage all community stakeholders to work with health departments and health care providers . . . to improve Wisconsin's health

[a] Eight of these sets were selected from the 35 indicator sets identified and reviewed by Wold in 2008 (26) for the Institute of Medicine's State of the USA Committee. The ninth indicator set was developed by the Institute of Medicine's State of the USA Committee. The criteria used for selecting the indicator sets displayed in this table from the 36 candidate indicator sets were that the indicator set contained both health outcome indicators and a specific stated purpose.

Table 3. Characteristics for Which Inequalities in Health Can Be Measured by Using 1 State Survey (BRFSS), Data from 2 National Surveys (NHIS, NSDUH), and NVSS Mortality Data

Return

Characteristic	BRFSS	NHIS	NSDUH	NVSS
Age	X	X	X	X
Citizenship		X		
Education level	X	X	X	X
Employment status	X	X	X	
Ethnicity	X	X	X	X

Geographic region			X	
Income	X	X		
Insurance status		X		
Marital status	X			X
National origin				X
Place of birth		X		
Place of residence	X		X	X
Race	X	X	X	X
Sex	X	X	X	X

Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System; NHIS, National Health Interview Survey; NSDUH, National Survey on Drug Use and Health; NVSS, National Vital Statistics System.

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Quality Measures and Impact

Types of measures

Structure: the capacity, systems, and processes to promote and/or provide high-quality care.

Process: the effectiveness and capability of process(es). These measures may include output and quality control measures.

Outcome: reflect the impact of the health care service or intervention on the health status of patients. These include population health measures

NCHC has high degree of impact and accountability

NCHC can influence and impact through the collaborative care model and collective impact initiatives

NORTH CENTRAL COMMUNITY SERVICES PROGRAM BOARD
EXECUTIVE COMMITTEE

July 13, 2016 2:00 PM North Central Health Care – Granite Room

Present: Jeff Zriny, Bob Weaver, Jean Burgener, Robin Stowe

Also Present: Michael Loy, Ben Bliven

Chairman Zriny called the meeting to order at 2:04 pm.

Action: Approve 06/14/2016 Executive Committee meeting minutes

- **Motion** to approve the 06/14/2016 Executive Committee meeting minutes made by Bob Weaver, seconded by Jean Burgener, motion passed 4-0.

Discussion on Morningside Report

- All Committee members received the report in advance of the meeting. The Morningside Report and corresponding outcomes from the presentations on July 11th and July 12th was reviewed. The committee discussed the options for the path forward and concerns with elements of the process and report. The using home should be considered more deeply and protected as a key piece of NCHC's services. There were many concerns shared with the overall scope of the report, lack of depth, and some key inaccuracies. Michael was directed to forward these to Morningside.

Update on Policy Question and Criteria, Transition Oversight Task Force and Administrator's Work Group Progress

- Process following the report and presentations and the implications of each of the options were discussed. The direction appears to be a blend of options 1 and 2. Status quo is not an option, but a new tri-county contract with ability to sign additional performance contracts could be supported by NCHC. Next the Marathon County Health and Human Services Committee will meet jointly with the Executive Committee to start to formulate a more formal recommendation. Additional information was also sent to the County Administrator for work scheduled with the Administrators Work Group who will be meeting again in July. NCHC is prepared to focus on a path forward with three key points to share with the County Board.
    1) Terminating the contract with NCHC creates destabilizing uncertainty for the residents of our three counties and the employees who serve them.
    2) We embrace amending the tri-county contract to create a bridge to a performance-based contracting relationship which allows for control of services, quality, and costs. This includes putting County funded dollars at risk for non-performance.
    3) Accountability and transparency are shared interests. We are committed to the performance-based budgeting process as a road to clear understanding of costs.
- Michael will work to support this direction around these shared interests.

Communication from the Department of Health Services (DHS)

- The Committee reviewed both the letter from DHS and cover letter from Michael. Small modifications were recommended to the cover letter. Discussion on how to share this information with Marathon County occurred. Michael requested he and Jeff be given time to speak with Chairman Gibbs prior to the letter and cover letter going out but that these both should be sent to the entire County Board. Committee would like the letter to not be sent with unreasonable delay so we are not accused of sitting on the letter.

CEO Report

- Met with the Medical College representatives regarding the launch of the Psychiatry Residency program in 2017. Serious concerns exist about NCHC's ability to provide the supervision for residents for both the Inpatient and Emergency Services rotation without a staff Psychiatrist in Inpatient. Using Locum Tenens, contracted Psychiatrists, is not allowed by the accrediting agencies.
- NCHC experienced the worst month this year in June. We are projecting significant financial pressure in 2016. A financial review and action plan will occur at the July Board meeting.
- We continue to struggle with Leadership Stability. We have interim leadership in a number of key areas and another Director just gave notice. Continued uncertainty with Marathon County has destabilized confidence and we expect more key turnovers and difficulty recruiting if a firm path forward is not set soon.

Agenda for 7/28/16 Board meeting

- Financial Review
- Update on the Crisis Process Improvement Team
- Operational Plan Update

J. Zriny requested the Board agenda list action items with assignments of responsibility.

Future agenda items for committee consideration
No items were requested.

Motion by J. Burgener to adjourn at 3:46 p.m., seconded by R. Stowe, motion carried 4-0.

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
FINANCE, PERSONNEL & PROPERTY COMMITTEE MEETING MINUTES

June 30, 2016 | 11:00 a.m. | NCHC – Wausau Health Care Center

Present:

X	Randy Balk	X	Bill Miller	EXC	Robin Stowe
X	Bob Weaver	X	Jeff Zriny		

Others Present: Michael Loy, Brenda Glodowski, Kristi Kordus

The meeting was called to order at 11:00 AM, roll call taken, and a quorum noted.

Minutes

- **Motion**/second, Miller/Balk, to approve the minutes of the 5/26/16 Finance, Personnel & Property Committee meeting. Motion carried.

Financials

- May shows a deficit of $343,000. Contributing factors include lower than average hospital census of 12, target is 14; nursing home census improved slightly at 209, target is 210; Medicare census dropped to 21 for May, target is 23.
- CBRF revenue is down.
- Expenses continue to be high particularly in health insurance at $119,000 over budget for May. June is on track to be higher than May. There are several high cost claims that are driving this trend. We will have to adjust for next year with plan changes.
- Crisis and hospital areas exceed targets.
- Marathon County has not made payments for the additional services being provided to Marathon County in 2016 which amounts to just under $200,000 through May. Marathon County relayed they are unsure when we can expect payment. The Performance Management Contract would encompass this payment and has been ready for signature but has not yet been signed; this is new this year due to the added services for the jail and is separate from the normal levy. Ms. Kordus stated the amount was approved in a separate contingency and must go to full county board with 2/3 vote, which will move expense from contingency to expenditure. Item needs to be put on Finance agenda and it was suggested this be done in August and include what has been completed.
- Diversions total was roughly $300,000 for May. Improvement has been made with Trempealeau County costs. The state institute is about the same. There has been an increase in services for under age 13 population (NCHC is not able to accept this age group) and individuals needing long term psychiatric help (we are a short-stay hospital with an average length of stay of 4-5 days).
- Low census in the nursing home appears to be directly related to the delay by the county board to remodel the facility which was predicted in the Wipfli report a couple years ago if the project was not done.
- A detailed analysis and strategy to address these budget concerns will be provided at the next committee meeting.

CFO report

- Days in accounts receivable went down to 58 days.
- The transition in nursing home billing is going well. On target to go live in July and anticipate significant improvements in nursing home billing.

Update on 2017 Budget Process

- Budget process is going well. Will provide additional updates in coming months.

Presentation and Discussion of Fund Balance

- With newer membership on the committee it was felt it would be beneficial to revisit this topic as there is often a misunderstanding that fund balance equals cash, but it is not all cash.
- Fund Balance was reviewed and discussed.

Discussion of Investment Policy

- Ms. Kordus was asked to attend to review Marathon County's investment policy and share her perspective on NCHC's policy, providing direction on how to handle the risk of our portfolio, etc.
- When the policy was established in 2012 it was intended to be simple and safe. The objective was to increase invested cash to 90 days (based on industry and volatility of industry).
- Ms. Kordus indicated the County wants funds to be comprehensive, safe, secure, gives liquidity, and feels there are better options than collateralizing at Marathon County banks.
- Following discussion, it was determined that Ms. Kordus will meet with Mr. Loy and Ms. Glodowski to evaluate NCHC's investment policy. It was noted that NCHC may not be in a position to make changes this year.
- Will look for a recommendation in August with highest level of security and return.

Motion/second, Miller/Balk, to adjourn the Finance, Personnel & Property Committee meeting. Motion carried. Meeting adjourned at 11:55 a.m.

dko

North Central Health Care
Person centered. Outcome focused.

QUALITY OUTCOME DASHBOARD

DEPARTMENT: NORTH CENTRAL HEALTH CARE FISCAL YEAR: 2016

PRIMARY OUTCOME GOAL	Continuous Improvement Target	Benchmark	⇧⇩	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
PEOPLE																
Vacancy Rate	**6-8%**	**N/A**	⇩	8.0%	5.8%	4.8%	5.2%	3.9%	6.2%							**5.9%**
Employee Turnover Rate*	**20-23%**	**17%**	⇩	19.6%	29.2%	29.3%	28.4%	26.3%	27.6%							**27.6%**
SERVICE																
Patient Experience: Satisfaction Percentile Ranking	**70-84th Percentile**	**N/A**	⇧	53rd	48th	45th	46th	53rd	48th							**48th**
Community Partner Satisfaction	**75-80%**	**N/A**	⇧	\	\	77%	\	\	72%							**75%**
CLINICAL																
Nursing Home Readmission Rate	**11-13%**	**18.2%**	⇩	13.8%	6.7%	12.0%	10.7%	14.8%	21.1%							**12.7%**
Psychiatric Hospital Readmission Rate	**9-11%**	**16.1%**	⇩	12.8%	11.1%	3.2%	5.0%	7.2%	11.4%							**8.4%**
AODA Relapse Rate	**18-21%**	**40-60%**	⇩	30.0%	33.3%	20.7%	25.0%	24.3%	27.3%							**26.8%**
COMMUNITY																
Crisis Treatment: Collaborative Outcome Rate	**90-97%**	**N/A**	⇧	\	\	\	\	100.0%	97.9%							**99.1%**
Access to Behavioral Health Services	**90-95%**	**NA**	⇧	58%	65%	87%	86%	92%	93%							**78%**
Recidivism Rate for OWI	**27-32%**	**44.7%**	⇩	22.6%	20.5%	29.2%	28.2%	18.2%	7.7%							**22.2%**
FINANCE																
***Direct Expense/Gross Patient Revenue**	**58-62%**	**N/A**	⇩	71%	65%	66%	64%	65%	67%							**67%**
Days in Account Receivable	**60-65**	**54**	⇩	70	65	64	64	58	51							**51**

KEY: ⇧ **Higher rates are positive**
⇩ **Lower rates are positive**

*** Monthly Rates are Annualized**

Target is based on a 10%-25% improvement from previous year performance or industry benchmarks.

NCHC OUTCOME DEFINITIONS

PEOPLE	
Vacancy Rate	Total number of vacant positions as of month end divided by total number of authorized positions as of month end.
Employee Turnover Rate	Percent of employee terminations (voluntary and involuntary) of the total workforce. Monthly figures represent an annualized rate. *Benchmark: Society of Human Resource Management (SHRM) for the north central region of the U.S.*
SERVICE	
Patient Experience: Satisfaction Percentile Ranking	Comparison rate (to other organizations in the Health Stream database) of the percent of level 9 and 10 responses to the Overall rating question on the survey. *Benchmark: HealthStream 2015 Top Box Percentile*
Community Partner Satisfaction Percent	Percentage of "Good and Excellent" responses to the Overall Satisfaction question on the survey.
CLINICAL	
Nursing Home Readmission Rate	Number of residents re-hospitalized within 30 days of admission to nursing home / total admissions. *Benchmark: American Health Care Association/National Center for Assistive Living (AHCA/NCAL) Quality Initiative*
Psychiatric Hospital Readmission Rate	Percent of patients who are readmitted within 30 days of discharge from the Inpatient Behavioral Health hospital for Mental Health primary diagnosis. *Benchmark: Medicare Psychiatric Patients & Readmissions in Impatient Psychiatric Facility Prospective Payment System, May, 2013, The Moran Company*
AODA Relapse Rate	Percent for patients admitted to Ambulatory Detoxification or the Behavioral Health hospital for detoxification then readmitted within 30 days of discharge for repeat detoxification. *Benchmark: National Institute of Drug Abuse: Drugs, Brains, and Behavior: The Science of Addiction*
COMMUNITY	
Crisis Treatment: Collaborative Decision Outcome Rate	Total number of positive responses(4 or 5 response on a 5 point scale) on the collaboration survey distributed to referring partners in each encounter in which a referral occurs.
NCHC Access	% of clients obtaining services within the Best Practice timeframes in NCHC programs. • Adult Day Services - within 2 weeks of receiving required enrollment documents • Aquatic Services - within 2 weeks of referral or client phone requests • Birth to 3 - within 45 days of referral • Community Corner Clubhouse - within 2 weeks • Community Treatment - within 60 days of referral • Outpatient Services - within 14 days of referral • Prevocational Services - within 2 weeks of receiving required enrollment documents • Residential Services - within 1 month of referral
Recidivism Rate for OWI	Percentage of people that recieve there OWI services from NCHC and then reoffend. *Benchmark: 2012-OWI Related Convictions by Violation County and Repeat Offender Status, State of Wisconsin DOT, Bureau of Driver Service, Alcohol & Drug Review Unit*
FINANCE	
Direct Expense/Gross Patient Revenue	Percentage of total direct expense compared to gross revenue.
Days in Account Receivable	Average number of days for collection of accounts. *Benchmark: WIPFLI, sources 2015 Almanac of Hospital Financial and Operating Indicators published by Optum-Psychiatric Hospitals, 2013 data.*

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
HUMAN SERVICES OPERATIONS COMMITTEE
MEETING MINUTES

July 18, 2016 **8:00 a.m.** **NCHC – Wausau Campus**

Present:

X	John Robinson	EXC	Holly Matucheski	X	Greta Rusch
X	Scott Parks	EXC	Nancy Bergstrom	X	Lee Shipway
X	Linda Haney				

Others Present: Michael Loy, Laura Scudiere, Brenda Glodowski, Becky Schultz, Sue Matis

The meeting was called to order, roll call was noted, and a quorum declared.

Consent Agenda

- In-depth discussion regarding current financial status including:
  - $680,000 above target through June.
  - State institute expenses continue to be high.
  - Costs associated with crisis services and additional services to the jail:
    - Phase 1: additional staff with higher educational level i.e. Bachelor or above, which increases salaries.
    - Phase 2: in progress with hiring youth workers and transportation workers; expenses have not yet been incurred.
  - Continue to look into the diversions made to Trempealeau County; have reduced the number from 5 to 2 and are reviewing the 2 cases with the goal to bring back to NCHC.
  - Marathon County had promised an additional $475,000 for the additional jail services; we have not yet received any payment.
  - Next meeting discussion will include: 1) Who is being placed at Trempealeau County, details on costs involved, opportunities to bring back to NCHC and costs; 2) Diversions and state institutes; 3) Crisis Services projected for remainder of 2016, benefit to population in Marathon County; 4) Fiscal year plan for HSO.
- **Motion**/second, Shipway/Rusch, to approve the consent agenda. Motion carried.

Juvenile Criminal Justice Discussion

- Unable to confirm presenter for July meeting. Will look for a presentation in August.

Morningside Report Discussion

- Purpose of hiring Morningside was to provide needs assessment and identify unmet needs throughout the county.
- Report recommended the following options: 1) continue current multi-county agreement with clear expectations and performance measures; 2) contract for services; 3) single county human service model; 4) multi-county human service approach
- Morningside is recommending Option 2 which is to pull out of the current 51.42 relationship and instead contract for services by releasing RFP's.

- Currently the county is considering contracting with NCHC for three years to allow for performance standards in a revised contract, and continue the relationship with Langlade and Lincoln Counties. However, the expectations have not yet been identified.
- The county asked for additional transparency from NCHC with more detailed financial information sent regularly to the Deputy Administrator. With the retirement of the Deputy Administrator it was recommended the information continue to be forwarded to Matt Bootz.
- Committee members agreed that it is an important time and an opportunity to develop a community behavioral health summit and include the epidemic and explosion of the increase use of opioids and meth in the community. NCHC should play a leadership role.

Inpatient Hospital Admission Policy Regarding Adolescents (ages 13-18)

- NCHC currently admits 13-18 year olds which allows adolescents to stay in their own community, be closer to their support networks, and eliminate transportation needs.
- Two issues relate to the admission of adolescents: mixing ages 13-18 with the adult population and psychiatrists do not approve of this care setting which makes added difficulties in securing psychiatrists to provide services.
- When adolescents are on the unit they cannot be mixed with the adult population and we must have higher staffing ratios.
- Consideration is being requested to transport the youth who need inpatient treatment to either Bellin or Winnebago. This would allow all beds to be utilized to unit capacity which would offset the costs for transporting the youth to another facility. Financial costs of this change in practice would need to be reviewed in detail along with the impact in the community.
- Continue to look to recruit child psychiatrists.
- Exploring the development of a smaller youth inpatient unit. We are struggling with youth in the community and our inpatient volumes for youth are up; our medical staff is in support; but impacts of a decision for transportation, cost, and care in the community are vital in making this decision. Will look for feedback from the community before looking at a potential change in service.
- Suggestion was made to inform Marathon County as to why we are exploring this option, issues being faced, costs, and seek their input. Recommended information to gather;
    - number of juveniles that need inpatient treatment who aren't receiving it in this county
    - number on juveniles on Medical Assistance
    - long term goal/timeline of inpatient unit for child and adolescents
- Committee was reminded that law indicates if we are licensed for more than 16 psychiatric hospital beds we are considered an IMD (Institute for Mental Disease) which means we would lose Medicaid funding.
- **Motion**/second, Shipway/Haney, to advance an evaluation of the policy regarding adolescents in the inpatient hospital. Motion carried.

Human Services Operations Outcome Reporting

- Executive Summary for Outcome Data was distributed and reviewed.
    - Will add data related to age i.e. adults and adolescents.
    - Have engaged Laura Yarie, but she unable to attend a meeting before the fall.
    - Will add a percentage on how many individuals were referred but didn't get scheduled.
    - Will include a combined financial report in addition to the breakdown of all three counties.

Human Services Operations Committee Charter

- **Motion**/second, Shipway/Parks, to advance the Human Services Operations Committee Charter to the Board for approval. Motion carried.

Future agenda items

- Inpatient Hospital Admission Policy Regarding Adolescents (ages 13-18) – continue discussion
- Juvenile Criminal Justice Discussion
- Morningside Report

Motion/second, Parks/Rusch, to adjourn the meeting at 9:30 a.m. Motion carried.

dko

NORTH CENTRAL COMMUNITY SERVICES PROGRAM
NURSING HOME OPERATIONS COMMITTEE MEETING MINUTES

July 15, 2016 8:00 A.M. NCHC – Wausau Campus

Present:	X	Jean Burgener	X	Bill Metter	X	Bill Miller
	X	John Robinson	X	Margaret Donnelly		

Also Present: Michael Loy, Kim Gochanour, Sue Matis, Brenda Glodowski

The meeting was called to order at 8:02 a.m.

Minutes

- **Motion**/second, Metter/Donnelly, to approve the 6/17/16 Nursing Home Operations Committee meeting minutes. Motion carried.

Financial Report

- There was a loss of $314,000 for the month of June.
- Census averaged 203. Area nursing facilities are also running low census.
- Protective Placements are mostly on the dementia unit and not as high as reported in the Morningside report.
    - Our dementia unit cares for the difficult behavioral population where area nursing homes may not have the capabilities to manage these behaviors.
    - We regularly review the cases of residents who have been moved to an alternative county facility and identify if care can be provided here. Every opportunity is explored to bring residents back when possible.
    - The Morningside Report uses the term 'post-acute' incorrectly; terminology is different in the long term care industry versus the acute hospital industry.
    - It was felt that the Morningside Report has a misunderstanding of our licensure.
    - Committee asked Ms. Burgener and Mr. Loy to communicate these misunderstandings to Morningside Consultants.
- The current deficit of $940,000 was reviewed and discussed in depth including payer mix, census, employee benefits/health insurance, staffing ratio, etc. Committee and staff feels there is an urgency to dive deep into the situation with a meticulous cost analysis. Options will be explored to increase revenue and decrease expenses including the possibility to decertify nursing home beds, staffing mix, regulatory staffing perspective, etc.
    - Committee requested a weekly update and should include a comparison of where we were at on June 30, 2015 and what happened to get to this point on June 30, 2016.
    - If staffing is expected at a 5 Star level, will county contribute at this level? What is the impact of hiring staff and reducing contracted staff on overtime, benefits, etc.?
    - Health insurance detail should include increased costs, number of claims, in what period of time, can we limit exposure, where are stop losses at, can we minimize the ups and downs, etc.
    - $335,000 of $900,000 deficit is due to health insurance claims; however over the last 4-5 years we had experienced a savings due to low claims in those years.

- Are we maximizing our accounting systems for reimbursement? Properly coding to reduce write-offs? Conversion to different billing system should be completed in the next week and we anticipate a marked improvement in the billing process.
- Requested a more detailed report to review direct and indirect costs including benefits, productive time, plus a comparison to last year, as well as industry standards.

Senior Executive Nursing Home Operations and Quality Report

- Handout on Vent Unit Capacity in Wisconsin was reviewed.
- Discussion on 'bundling payments' requested for a future agenda.
- Nursing Home Quality Action Plan is in progress (PowerPoint included in the packet).
- Team-Based Leadership has been instituted again to lead teams in each neighborhood, redefined meeting structure to help staff be on the floor more and be more effective, working on an annual training plan for employees, looking at a standardization of care, establishing a rapport with surveyors which will help to better manage a survey.

Charter Outcome Review

- Six new quality indicators will be part of the 5 Star Report, however, they will not be counted in the analysis until January 2017.

Review of Therapy Costs

- Rehab Analysis Summary was distributed and reviewed.
  - Looked at three month comparison of two therapy companies.
  - Current rate is $.94/minute which is a better rate than the usual rate. Anticipate the lower census will begin to impact rehab financial performance.

Morningside Report

- Committee member asked what the termination section in the current nursing home operating agreement indicates between the county and North Central Health Care. John Robinson indicated he would forward the historical nursing home agreement to Michael Loy from the Governance Task Force documentation.
- Any factual issues and/or disputes with the report should be forwarded to Michael Loy who will share with appropriate County representatives.
- Concern expressed at the emphasis of a 5-year strategic document that NCHC was asked to create in a month's time and a requirement for the CIP process; concern there isn't clarity between the 51.42 system and the nursing home although NCHC has changed their reporting to help with a better understanding on the operational costs.
- A request for a comprehensive 20 year plan for structural items i.e. boiler, windows, roof, etc. is necessary. Difficult to predict what reimbursement will be but can break out the facility needs, population in county, trends for reimbursement may be important.
- Committee scheduled a special meeting for 7/29/16 at 7 a.m. to continue to review the current budget situation.

Future Agenda Items for Committee Consideration

- Bundled payment education – request Navi Health to review report

Motion/second, Metter/Miller to adjourn the meeting 9:50 a.m. Motion carried.

dko

North Central Health Care
Person centered. Outcome focused.

MEMO

TO: **North Central Health Care Finance Committee**
FROM: **Brenda Glodowski**
DATE: **July 22, 2016**
RE: **Attached Financials**

Attached please find a copy of the June Financial Statements for your review. To assist in your review, the following information is provided:

BALANCE SHEET

Most areas remain consistent with prior months with Accounts Receivable continuing to improve.

STATEMENT OF REVENUE AND EXPENSES

The month of June shows a loss of $491,299 compared to the targeted gain of $55,863, resulting in a negative variance of $547,162.

Overall revenue fell below target for June. The nursing home census continues to struggle, averaging 203 per day compared to the target of 210. The Medicare census also dropped in June averaging 19 per day compared to the target of 23. The hospital census improved compared to May, but was still just below the target of 14. There was a decrease in some of the Outpatient areas. It is normal to see a decline in this area during the summer months.

Overall expenses continue to exceed budget targets. Health insurance continues to exceed targets and is over by $221,000 for the month. State Institutes also continue to exceed targets and are over by $112,000 for the month. Crisis Services continues to exceed targets and will continue to exceed targets for the remainder of the year.

Leadership is involved with an expense reduction plan to assist with bringing down expenses in other areas for the remainder of the year.

If you have questions, please feel free to contact me.

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF NET POSITION
JUNE 2016

	Human Services	Nursing Home	Total	Prior Year Combined
Current Assets:				
Cash and cash equivalents	3,283,274	1,435,472	4,718,746	7,086,919
Accounts receivable:				
Patient - Net	2,975,954	3,028,418	6,004,372	7,190,137
Outpatient - WIMCR	505,000	0	505,000	418,000
Nursing home - Supplemental payment program	0	0	0	476,346
Marathon County	224,341	0	224,341	72,809
Net state receivable	521,293	0	521,293	1,339,650
Other	376,911	0	376,911	161,786
Inventory	0	303,535	303,535	273,822
Other	566,484	465,927	1,032,411	443,289
Total current assets	8,453,256	5,233,352	13,686,608	17,462,757
Noncurrent Assets:				
Investments	9,800,000	0	9,800,000	7,150,831
Assets limited as to use	1,937,716	893,082	2,830,798	2,149,169
Restricted assets - Patient trust funds	25,152	37,037	62,189	56,619
Net pension asset	2,659,515	2,187,423	4,846,938	0
Nondepreciable capital assets	268,291	542,370	810,660	1,302,565
Depreciable capital assets - Net	7,518,334	3,312,692	10,831,026	10,403,333
Total noncurrent assets	22,209,007	6,972,604	29,181,611	21,062,518
Deferred outflows of resources - Related to pensions	2,662,206	2,189,636	4,851,842	0
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	33,324,469	14,395,592	47,720,061	38,525,275

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF NET POSITION
JUNE 2016

	Human Services	Nursing Home	Total	Prior Year Combined
Current Liabilities:				
Current portion of related-party note payable	151,257	0	151,257	148,264
Accounts payable - Trade	849,864	699,004	1,548,868	1,683,089
Appropriations advances	0	0	0	0
Accrued liabilities:				
Salaries and retirement	849,164	698,429	1,547,593	1,279,729
Compensated absences	923,139	759,272	1,682,411	1,643,932
Health and dental insurance	470,236	386,764	857,000	652,000
Other Payables	249,704	205,379	455,083	422,809
Amounts payable to third-party reimbursement programs	255,920	0	255,920	405,214
Unearned revenue	135,146	0	135,146	188,536
Total current liabilities	3,884,430	2,748,848	6,633,279	6,423,573
Noncurrent Liabilities:				
Related-party note payable	636,181	0	636,181	787,438
Patient trust funds	25,064	37,037	62,101	56,619
Total noncurrent liabilities	661,245	37,037	698,282	844,057
Total liabilities	4,545,675	2,785,885	7,331,561	7,267,630
Deferred inflows of resources - Related to pensions	46,570	38,303	84,873	0
Net Position:				
Net investment in capital assets	7,786,625	3,855,062	11,641,686	11,705,898
Unrestricted	16,351,819	4,321,302	20,673,121	17,976,368
Restricted - Pension benefit	5,269,447	4,334,065	9,603,512	0
Operating Income / (Loss)	(675,667)	(939,025)	(1,614,692)	1,575,379
Total net position	28,732,224	11,571,404	40,303,627	31,257,645
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	33,324,469	14,395,592	47,720,061	38,525,275

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING JUNE 30, 2016

TOTAL	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$3,438,134	$3,589,874	($151,741)	$21,283,109	$21,557,009	($273,900)
Other Revenue:						
State Match / Addendum	324,658	325,120	(462)	1,947,948	1,950,718	(2,770)
Grant Revenue	202,293	190,538	11,754	1,186,256	1,143,410	42,846
County Appropriations - Net	740,619	740,566	53	4,443,714	4,443,394	320
Departmental and Other Revenue	186,559	200,583	(14,024)	1,128,157	1,203,798	(75,641)
Total Other Revenue	1,454,128	1,456,807	(2,678)	8,706,075	8,741,320	(35,245)
Total Revenue	4,892,262	5,046,682	(154,419)	29,989,183	30,298,329	(309,145)
Expenses:						
Direct Expenses	4,116,276	3,603,715	512,561	23,865,429	21,697,966	2,167,464
Indirect Expenses	1,277,706	1,394,604	(116,898)	7,809,406	8,496,923	(687,517)
Total Expenses	5,393,982	4,998,319	395,663	31,674,835	30,194,889	1,479,946
Operating Income (Loss)	(501,720)	48,363	(550,083)	(1,685,651)	103,440	(1,789,091)
Nonoperating Gains (Losses):						
Interest Income	10,039	7,500	2,539	57,271	45,000	12,271
Donations and Gifts	382	0	382	13,689	0	13,689
Gain / (Loss) on Disposal of Assets	0	0	0	0	0	0
Total Nonoperating Gains / (Losses)	10,421	7,500	2,921	70,960	45,000	25,960
Income / (Loss)	($491,299)	$55,863	($547,162)	($1,614,692)	$148,440	($1,763,132)

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING JUNE 30, 2016

51.42./.437 PROGRAMS	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$1,522,794	$1,549,246	($26,452)	$9,376,186	$9,221,751	$154,435
Other Revenue:						
State Match / Addendum	324,658	325,120	(462)	1,947,948	1,950,718	(2,770)
Grant Revenue	202,293	190,538	11,754	1,186,256	1,143,410	42,846
County Appropriations - Net	598,953	598,899	54	3,593,718	3,593,394	324
Departmental and Other Revenue	145,503	169,287	(23,785)	820,975	1,016,025	(195,050)
Total Other Revenue	1,271,406	1,283,844	(12,438)	7,548,896	7,703,547	(154,650)
Total Revenue	2,794,200	2,833,091	(38,890)	16,925,082	16,925,297	(215)
Expenses:						
Direct Expenses	2,301,799	1,991,342	310,457	13,373,408	11,992,225	1,381,183
Indirect Expenses	679,508	797,418	(117,910)	4,294,559	4,858,439	(563,880)
Total Expenses	2,981,307	2,788,759	192,548	17,667,967	16,850,664	817,303
Operating Income (Loss)	(187,107)	44,331	(231,438)	(742,884)	74,633	(817,518)
Nonoperating Gains (Losses):						
Interest Income	10,039	7,500	2,539	57,271	45,000	12,271
Donations and Gifts	0	0	0	9,947	0	9,947
Gain / (Loss) on Disposal of Assets	0	0	0	0	0	0
Total Nonoperating Gains / (Losses)	10,039	7,500	2,539	67,218	45,000	22,218
Income / (Loss)	($177,068)	$51,831	($228,899)	($675,667)	$119,633	($795,300)

NORTH CENTRAL HEALTH CARE
COMBINING STATEMENT OF REVENUES AND EXPENSES
FOR PERIOD ENDING JUNE 30, 2016

NURSING HOME	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	YTD ACTUAL	YTD BUDGET	YTD VARIANCE
Revenue:						
Net Patient Service Revenue	$1,915,339	$2,040,628	($125,289)	$11,906,923	$12,335,258	($428,335)
Other Revenue:						
County Appropriations - Net	141,666	141,667	(1)	849,996	850,000	(4)
Departmental and Other Revenue	41,056	31,296	9,761	307,182	187,773	119,409
Total Other Revenue	182,722	172,962	9,760	1,157,178	1,037,773	119,405
Total Revenue	2,098,061	2,213,590	(115,529)	13,064,101	13,373,032	(308,930)
Expenses:						
Direct Expenses	1,814,477	1,612,373	202,104	10,492,021	9,705,740	786,281
Indirect Expenses	598,197	597,186	1,011	3,514,847	3,638,485	(123,637)
Total Expenses	2,412,675	2,209,559	203,115	14,006,868	13,344,225	662,643
Operating Income (Loss)	(314,614)	4,031	(318,644)	(942,767)	28,807	(971,574)
Nonoperating Gains (Losses):						
Interest Income	0	0	0	0	0	0
Donations and Gifts	382	0	382	3,742	0	3,742
Gain / (Loss) on Disposal of Assets	0	0	0	0	0	0
Total Nonoperating Gains / (Losses)	382	0	382	3,742	0	3,742
Income / (Loss)	($314,232)	$4,031	($318,263)	($939,025)	$28,807	($967,832)

NORTH CENTRAL HEALTH CARE
REPORT ON AVAILABILITY OF FUNDS
30-Jun-16

BANK	LENGTH	MATURITY DATE	INTEREST RATE	AMOUNT	Collateralized
Abby Bank	365 Days	07/19/2016	0.75%	$500,000	X
People's State Bank	365 Days	08/21/2016	0.50%	$500,000	
BMO Harris	395 Days	08/26/2016	0.50%	$500,000	
Abby Bank	365 Days	08/29/2016	0.75%	$500,000	X
Abby Bank	456 Days	09/01/2016	0.95%	$500,000	X
CoVantage Credit Union	456 Days	09/01/2016	1.00%	$500,000	
People's State Bank	365 Days	10/30/2016	0.55%	$500,000	
Abby Bank	365 Days	01/06/2017	0.75%	$500,000	X
Abby Bank	730 Days	02/25/2017	0.80%	$500,000	X
People's State Bank	395 Days	03/28/2017	0.65%	$250,000	
CoVantage Credit Union	455 Days	03/30/2017	1.00%	$500,000	
CoVantage Credit Union	578 Days	05/07/2017	1.05%	$500,000	
BMO Harris	365 Days	05/28/2017	0.80%	$500,000	
People's State Bank	395 Days	05/29/2017	0.75%	$350,000	
People's State Bank	395 Days	05/30/2017	0.75%	$500,000	
CoVantage Credit Union	578 Days	07/28/2017	1.10%	$300,000	
Abby Bank	730 Days	10/29/2017	1.10%	$500,000	X
CoVantage Credit Union	730 Days	11/18/2017	1.10%	$500,000	
Abby Bank	730 Days	12/30/2017	1.10%	$500,000	X
Abby Bank	730 Days	03/15/2018	1.20%	$400,000	X
Abby Bank	730 Days	05/03/2018	1.20%	$500,000	X
TOTAL FUNDS AVAILABLE				$9,800,000	
WEIGHTED AVERAGE	509.17 Days		0.873% INTEREST		

NCHC-DONATED FUNDS
Balance Sheet
As of June 30, 2016

ASSETS	
Current Assets	
Checking/Savings	
CHECKING ACCOUNT	
Adult Day Services	4,989.38
Adventure Camp	798.41
Birth to 3 Program	2,035.00
Clubhouse	24,077.86
Community Treatment	10,366.66
Fishing Without Boundries	3,913.00
General Donated Funds	61,633.73
Housing - DD Services	1,370.47
Langlade HCC	3,309.63
Legacies by the Lake	
Music in Memory	1,648.25
Legacies by the Lake - Other	3,858.49
Total Legacies by the Lake	5,506.74
Marathon Cty Suicide Prev Task	14,281.36
National Suicide Lifeline Stipe	3,176.37
Northern Valley West	1,966.00
Nursing Home - General Fund	1,874.69
Outpatient Services - Marathon	101.08
Pool	9,845.09
Prevent Suicide Langlade Co.	2,444.55
Resident Council	1,021.05
United Way	260.00
Total CHECKING ACCOUNT	152,971.07
Total Checking/Savings	152,971.07
Total Current Assets	152,971.07
TOTAL ASSETS	**152,971.07**
LIABILITIES & EQUITY	
Equity	
Opening Bal Equity	123,523.75
Retained Earnings	35,991.07
Net Income	-6,543.75
Total Equity	152,971.07
TOTAL LIABILITIES & EQUITY	**152,971.07**

North Central Health Care
Budget Revenue/Expense Report

Month Ending June 30, 2016

ACCOUNT DESCRIPTION	CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	YTD ACTUAL	YTD BUDGET	DIFFERENCE
REVENUE:					
Total Operating Revenue	4,892,262	5,046,682	29,989,183	30,298,329	(309,146)
EXPENSES:					
Salaries and Wages	2,477,874	2,551,520	14,993,258	15,379,166	(385,908)
Fringe Benefits	1,125,774	945,189	6,364,724	5,697,066	667,658
Departments Supplies	557,693	466,527	2,780,828	2,799,163	(18,334)
Purchased Services	481,260	265,981	2,406,931	1,635,888	771,043
Utilitites/Maintenance Agreements	289,581	316,097	2,007,042	1,965,580	41,462
Personal Development/Travel	44,055	39,229	215,731	235,375	(19,644)
Other Operating Expenses	102,497	153,317	619,837	919,901	(300,064)
Insurance	36,843	47,292	222,065	283,750	(61,685)
Depreciation & Amortization	94,675	138,167	766,082	829,000	(62,918)
Client Purchased Services	183,729	75,000	1,298,337	450,000	848,337
TOTAL EXPENSES	**5,393,982**	**4,998,319**	**31,674,835**	**30,194,889**	**1,479,946**
Nonoperating Income	10,421	7,500	70,960	45,000	25,960
EXCESS REVENUE (EXPENSE)	**(491,299)**	**55,863**	**(1,614,692)**	**148,440**	**(1,763,132)**

North Central Health Care
Write-Off Summary
June 2016

	Current Month	Current Year To Date	Prior Year To Date
Inpatient:			
Administrative Write-Off	$42,910	$134,844	$11,273
Bad Debt	$2,272	$10,516	$1,274
Outpatient:			
Administrative Write-Off	$27,546	$72,124	$40,974
Bad Debt	$2,037	$5,942	$4,783
Nursing Home:			
Daily Services:			
Administrative Write-Off	$5,069	$880	$2,483
Bad Debt	$11,562	$16,956	$23,300
Ancillary Services:			
Administrative Write-Off	$2,521	$7,248	$21,673
Bad Debt	$0	($126)	$0
Pharmacy:			
Administrative Write-Off	$0	$0	$0
Bad Debt	$0	$0	$0
Total - Administrative Write-Off	$78,046	$215,096	$76,403
Total - Bad Debt	$15,871	$33,288	$29,357

North Central Health Care
2016 Patient Days

Month		Budget	Actual	Variance	Budgeted Occupancy	Actual Occupancy
January	Nursing Home	6,510	6,441	(69)	87.50%	86.57%
	Hospital	434	402	(32)	87.50%	81.05%
February	Nursing Home	6,090	5,953	(137)	87.50%	85.53%
	Hospital	406	407	1	87.50%	87.72%
March	Nursing Home	6,510	6,363	(147)	87.50%	85.52%
	Hospital	434	459	25	87.50%	92.54%
April	Nursing Home	6,300	6,131	(169)	87.50%	85.15%
	Hospital	420	462	42	87.50%	96.25%
May	Nursing Home	6,510	6,467	(43)	87.50%	86.92%
	Hospital	434	377	(57)	87.50%	76.01%
June	Nursing Home	6,300	6,080	(220)	87.50%	84.44%
	Hospital	420	416	(4)	87.50%	86.67%
July	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
August	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
September	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
October	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
November	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%
December	Nursing Home			0	0.00%	0.00%
	Hospital			0	0.00%	0.00%

North Central Health Care
Person centered. Outcome focused.

2016 WORK PLAN

Update: July 2016

Objective	Outcome	Activity	Timeline	Progress
OVERACHING OPERATIONAL OBJECTIVE #1: ALIGN ALL EMPLOYEES AND SUPPORTING HUMAN RESOURCE SYSTEMS TO OVERALL PATIENT SERVICE EXCELLENCE RESULTS WITH SPECIFIC LEADERSHIP FOCUS ON THE EVALUATION AND DEVELOPMENT OF FRONT-LINE STAFF SERVICE EXCELLENCE.				
1) Strengthen role clarity and job design. Responsible person(s): Sue Matis	Clarity of expectations for staff to achieve role excellence.	a. Finish job description updates to establish job specific competencies. b. Rollout new Performance Management System. Organization Wide customer services training deployed.	a. Q2 b. Q3	-Hired Organizational Development Manager -Job Descriptions are complete and being reviewed by managers/staff for updates. -Performance Management System has been reviewed with Leaders and projected to roll out to staff in October. -Reviewing 2016 Core Competency training plan -Training for Technology backbone for performance and competency centers complete
2) Improve employee sourcing and development. Responsible person(s): Sue Matis	Decrease turnover, increase employee retention and skill level.	Develop Workforce planning strategy with key actions and deliverables	Q2	-HR Recruiter /Business Partner Candidate has been identified with solid healthcare background. Strategizing how to fill via - FTE neutral. -Established weekly recruitment meeting to

				discuss strategy, sourcing and success measures.
3) Enhance recognition programs. Responsible person(s): Sue Matis	Increase level of employee engagement and satisfaction.	a. Review Employee of the Month program b. Revitalize Witnessing Excellence program c. Develop local (program level) recognition support structure d. Deploy Service and Operational Excellence Award	On hold until further research and development of Patient Experience.	-Scheduled key events. -Complete: Ordered and will be delivering badge buddies to Nurses and CNAs for Nurses week. -Employee Recognition Week is scheduled for the week of 8/17/2016 -Chili lunch will be the week before Christmas.
4) Provide the tools and resources for serving patients directly. Responsible person(s): Kim Gochanour and Becky Schultz	The development of a new patient centered experience training module for North Central Health Care Center. To increase our patient satisfaction scores by providing a positive patient experience.	a. Establish Patient Experience Team to define the model. b. Roll out model/branding at Leadership meeting c. All Staff education on new patient experience model.	a. Q1 b. Q2 c. Q2 &3	a. Team has defined purpose and model. b. Training provided at May leadership meeting. c. All staff training began week of July 11 with completion in August 2016. Training is being incorporated for new employee orientation starting in September 2016.

Objective	Outcome	Activity	Timeline	Progress
OVERACHING OPERATIONAL OBJECTIVE #2: CONTINUE TO DEVELOP THE AVAILABILITY AND DIVERSE EXPERTISE OF BEHAVIROAL HEALTH SERVICES.				
1) Provide leadership in the delivery of the Psychiatry Residency program with the Medical College of Wisconsin. Responsible person(s): Michael Loy	The successful creation of the Psychiatry Residency program will increase the available Psychiatry from the residents and long-term employment of those who complete residency in 4-5 years.	The application for accreditation has been submitted and all partner sites have been committed along with securing a training director. Site visit was completed in February.	Matching process will begin this summer. Residency program launch will be in summer of 2017.	The application for accreditation was approved on May 2, 2016. We are currently recruiting to replace Dr. Ticho. The position would work part-time on the Inpatient unit in addition to serving as the Medical Director and in the academic role for the Medical College residency program.
2) Source appropriate mental health and substance abuse professionals to meet community needs. Responsible person(s): Sue Matis	Provide appropriate level of service to meet the needs.	a. Evaluating staffing model in Behavioral Health Services b. Develop detailed sourcing strategy plan Achieve <10% vacancy rate in mental health staffing (Need clarification on what is included in Mental Health Staffing)	a. Q1 b. Q1 and Q2	Connecting with Wisconsin Schools for Bachelor's and Master's trained professionals. Connections made with UWSP for Bachelor's Level professionals Evaluating staffing models in Crisis and Outpatient Services Vacancy report created Hired an additional therapist in Wausau and Clinical Coordinator for Outpatient. Crisis services staffing has been increased to provide

Objective	Outcome	Activity	Timeline	Progress
				adequate 24/7 mobile crisis. Majority have been filled as of June 2016. Connecting with Wisconsin Schools for Bachelor's and Master's trained professionals. Connections made with UWSP for Bachelor's Level professionals Evaluating staffing models in Crisis and Outpatient Services Vacancy report created
3) Strengthen NCHC's comprehensive crisis services care delivery model. Responsible person(s): Laura Scudiere and Becky Schultz	The strengthened partnership will result in improved partner satisfaction as evidenced by improved scores for the crisis unit.	Developed Crisis PI Team in October 2015- Action Plan includes: a. Advancement of Crisis Staff competency b. Provide Crisis Intervention training for partners c. Restructure Crisis Services Management Transportation service d. Expanded Crisis Care Model e. Establishment of Advancement of Medical Clearance capabilities at NCHC	a. Q1 and Q2 b. Q1 and Q2 c. Q2 and Q3 d. Q3 and Q4 e. Q3 and Q4	All new crisis workers have Bachelors or above educational requirement and competency validation process is in place. The first round of Crisis intervention education complete through Marathon County law enforcement. Phase 2 Plan for crisis restructure has been developed and was discussed and approved by HSO NCHC Board Committee and NCHC Board.

Objective	Outcome	Activity	Timeline	Progress
				A van has been secured for transportation program. Job descriptions have been developed, positions have been posted, hiring process has begun. Target go-live of August 1, 2016. Revised policies and practices for medical clearance have been determined by medical partners, and communicated to partners May 2016. Corporation Counsels of the three counties met and agreed upon requirements for emergency detentions. These are being developed into procedures. NCHC Court Liaison has been hired and trained. Crisis partner feedback cards have been developed and results are communicated on the NCHC Board dashboard on monthly basis.
4) Effectively partnering with the criminal justice system to reduce recidivism associated with mental health and substance abuse.	Improved partnership with law enforcement, as evidenced by partner satisfaction survey scores.	a. Crisis Intervention Training (CIP and CIT) b. Explore innovation in crisis response with law enforcement c. Develop strategy for improved	a. Q1 and Q2 b. Ongoing c. Ongoing	a. First round of CIP trainings has occurred. b. Staff from NCHC and MC Sheriff's department. Attended conference and

Objective	Outcome	Activity	Timeline	Progress
Responsible person(s): Laura Scudiere		communication		explored options. Team initiated to explore new models c. Regularly scheduled meetings with all partners within the criminal justice system are scheduled and occurring consistently.
5) Advancing practitioner development and competency. Responsible person(s): Sue Matis	Create a well-defined development system outlining job specific competencies needed in each positon that will meet the needs of NCHC patient centered model.	a. Build electronic competency based checklist for all advanced practitioners b. Training plan developed and validation outcomes met	a. Q3 b. Q3	a. Competency Model has been built and rolled out to leader. Next steps are to confirm accuracy of models.
6) Continued development of innovative services to address community mental health and substance abuse needs. Responsible person(s): Laura Scudiere & Becky Schultz	Additional treatment options (beds) in the community.	a. Develop a community group, much like Crisis P&I to discuss Substance Use in the community. b. Increase the number of beds for MMT and for Crisis CBRF.	Q3 and Q4	a. Speaking with MCHD partners and the HSO Committee to determine next steps on developing a plan for Collective Impact model for substance abuse in our communities. Discussions with the health department and WHIPPs has occurred on framing the model. b. Initial capital improvement plan submitted to Marathon County.

Objective	Outcome	Activity	Timeline	Progress
7) Deploy an internal Accountable Care Organization (ACO) model within the mental health and substance abuse services continuum of care by: a. Enhancing clinical coordination between programs to ensure effective transitions of care. b. Creating individual patient cost and outcome tracking mechanisms	This item will be addressed in future year plans.			

North Central Health Care
Person centered. Outcome focused.

2016 WORK PLAN

Update: July 2016

Objective	Outcome	Activity	Timeline	Progress
OVERACHING OPERATIONAL OBJECTIVE #3: HEIGHTENED FOCUS ON ELECTRONIC MEDICAL RECORD (EMR) SYSTEMS FUNCTIONING WITH THE FOLLOWING OUTCOMES:				
1) High clinical satisfaction with the interaction and functioning within EMR applications Responsible person(s): Brenda Glodowski & Becky Schultz	Both EMR systems, Tier and ECS, are working effectively to provide clinical functionality for NCHC. Staff is well trained and use the system appropriately.	A consultant was contracted with in December to review specific areas within the IT area. This work has been completed and a 2 part report has been released. The consultant has met with the Executive Team to review both reports. Recommendations on changes will be presented to the Executive Team by February 19. An Action Plan is being worked on. The action plan will be completed for presentation once the recommendations are reviewed. A draft charter for an IT Governance Committee is completed and has been distributed to the Executive Team for review and comment.	Q1 Q1 Q3 Q1	The recommendations from the consultant have been finalized and reviewed. There has been a change in leadership which should help redirect priorities and results. Planning session has been held with Net Smart staff, IT Governance Committee established and initiated. Outstanding Tier issues undergoing a prioritization process. Outstanding Tier issues have been prioritized and are being reviewed by IT Governance. The Governance Committee has met, and has completed first workshop. The second workshop is scheduled for June. The list of open IT items has been reviewed and significantly reduced The second workshop has been completed, as well as the committee's first meeting on its own.

				The ECS vendor has been on site and is building the nursing home billing system. This project is still on target. Billing from the ECS system is in the testing phase.
2) Systems communicate effectively to inform clinical decision making and patient care coordination. Responsible person(s): Becky Schultz	Implement process improvement team to ensure a centralized treatment planning process is utilized in the EMR	Initiate cross-functional team utilizing process improvement methodology to make decisions and necessary changes in the EMR	Q2 and Q3	The team has identified required treatment plan elements for all behavioral health programs and current EMR capabilities. They have begun to identify IT resources needed.
3) Data is interfaced, processes, managed and easily accessed for evaluation and outcome reporting. Responsible person(s): Brenda Glodowski	All systems work together as needed so information needed from the systems is accessible as needed. Outcome reporting will work as needed to comply with requirements.		Q3	This will be part of the upcoming action plan
4) Ability to exchange data with patient and other healthcare partners. Responsible person(s): Brenda Glodowski	Exchange of needed data between patient and other health providers.		Q4	Continuing to work with vendor for proper set up